Worth the Wait

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ABSTRACT

In this column, the editor of *The Journal of Perinatal Education* discusses disadvantages of not waiting for labor to begin on its own and the effects of elective induction and cesarean surgery. The editor also describes the contents of this issue, which offer a broad range of resources, research, and inspiration for childbirth educators in their efforts to promote, support, and protect natural, safe, and healthy birth.

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Editor

I recently saw an advertisement on television for a contact lens cleaner that boasted, “Clean your lenses in 5 minutes! Why have to wait overnight?” Come on now! How difficult is it to wait overnight while your lenses are peacefully soaking in a cleaning solution. I began to reflect on how we have become a society that has no patience to wait for anything. It seems we are always in a rush.

Take labor for example. Many more women today are choosing to have elective inductions of their labor or scheduled cesarean surgery rather than waiting for labor to begin on its own. Sometimes induction is for the convenience of the health-care provider, but often it is simply a decision of the expectant mother to avoid the inconvenience of having to wait. In an article for expectant parents on the Lamaze for Parents website entitled “When It Comes to Choosing a Birthday, Baby Knows Best,” Debby Amis (2012) comments,

Patience is truly a virtue after 9 long months, especially when you're a few weeks or days from your due date. The swollen feet, extra pounds and late-night

bathroom trips can take their toll. Wouldn't it be easier to just schedule your baby's birth and get the show on the road? (para. 1)

But there are advantages to waiting. We know that induction of labor increases the likelihood of the need for other interventions, such as intravenous fluids and continuous fetal monitoring. It is also associated with increased need for cesarean surgery. However, an often overlooked drawback of elective induction of labor or scheduled cesarean surgery is that although the mother may be ready to give birth, the baby may not be fully ready.

Full term is generally considered between 37 and 41 weeks. Newborns born before 37 weeks are often referred to as “preterm.” We now know that babies who are born near to full term (34–36 weeks) face increased chances for health and development problems. Although many late-preterm or near-to-full-term infants may look healthy, they often have problems feeding, sleeping, breathing, and regulating their temperature (Association of Women's Health, Obstetric and Neonatal Nurses, 2010).

We invite readers to respond to the contents of this journal issue or share comments on other topics related to natural, safe, and healthy birth. Responses will be published as a letter to the editor. Please send comments to Wendy Budin, Editor-in-Chief (wendy.budin@nyu.edu).

Although many late-preterm or near-to-full-term infants may look healthy, they often have problems feeding, sleeping, breathing, and regulating their temperature.

However, even babies considered “full term” are at risk for problems. Findings from a recent study conducted by Kimberly Noble, assistant professor of pediatrics at Columbia University Medical Center, and published in the journal *Pediatrics* indicated that even for infants born at what is currently considered full term, a little more time in the womb may make a difference (Noble, Fifer, Rauh, Nomura, & Andrews, 2012). The extra time results in more brain development and suggests perhaps better scores on academic tests later in life, as well. Noble and colleagues (2012) analyzed data from 128,050 singleton births in a large U.S. city and found that babies born at 37 weeks may do worse in math and reading tests later in life than babies born at 41 weeks. According to the authors, all the children in the study were full term, and most did fine on reading and math tests conducted when they reached the age for third grade. However, even though the differences were small, more children born at 37 or 38 weeks did poorly than children born even a week or two later. The researchers controlled for other risk factors that are known to be associated with developmental delays and poor academic performance, such as birth weight, lack of prenatal care, smoking during pregnancy, maternal education, and socioeconomic status, and they still found that birth at 37 and 38 weeks is an additional risk. According to the researchers, these findings raise additional questions about hastening childbirth by electively inducing labor or scheduling cesarean surgery for convenience rather than for medical reasons.

All parents want their children to be smart. This may be just one more reason why it is worth the wait to allow labor to begin on its own.

IN THIS ISSUE

Continuing the practice of advancing the Lamaze International mission to promote normal, healthy birth by sharing birth stories, this issue’s “Celebrate Birth!” column features a personal literary essay entitled “Freebirth” by Dr. Eric Freeze, assistant professor of English at Wabash College in Crawfordsville. Freeze describes his wife, Rixa, and their first home-birth experience.

We are excited to share an informative guest editorial by Lamaze board member Michele Ondeck who describes the new Lamaze International “Push for Your Baby” campaign to urge women to advocate for more evidence-based practice for better births. Ondeck also candidly reflects on her hopes and worries about the “Push for Your Baby” campaign launched by Lamaze in May 2012. The “Push for Your Baby” campaign encourages women to seek better maternity care for themselves and their babies. By incorporating a discussion of the realities of current maternity care practice, Ondeck raises some important questions about how we can effectively work with the obstetric team to have them support women in having a normal birth.

Kathleen Thielen provides a critical review of research articles that explore the group prenatal care model. Thielen creatively blended two middle range theories—Pender’s health promotion model and Swanson’s theory of caring—to enhance conceptualization of the relationship between pregnant women and the group prenatal care model. The author concluded that current research evidence demonstrates the value of group prenatal care as a potential method of improving perinatal outcomes within the pregnant population.

In the article “Men’s Perceptions of Pregnancy-Related Weight Gain: A Psychosocial Firestorm (Upheaval) Intertwined With Supportive Intentions,” Kristen Montgomery and colleagues discuss the findings from their qualitative study that involved in-depth interviews with 16 men who had a significant other who had given birth within the last 5 years. Men were asked about their perceptions of pregnancy-related weight gain and described nine themes related to perinatal weight gain: (a) negative perceptions, (b) eating behaviors, (c) exercise habits, (d) health impact, (e) body changes, (f) weight loss success, (g) “it bothered her more than me,” (h) “the weight gain wasn’t a problem,” and (i) intimacy. Together, these themes offer a glimpse into men’s experiences and highlight the discord and balance between experiencing negative feelings/perceptions and being a supportive partner. The authors suggest that this information on how men perceive pregnancy-related weight gain can be used to develop interventions to assist men to support their significant others in meeting weight-loss goals following pregnancy.

Kathrin Stoll and Wendy Hall describe findings from their study designed to examine the associations between attendance at childbirth education classes

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and maternal characteristics (age, income, educational level, single parent status), maternal psychological states (fear of birth, anxiety), rates of obstetric interventions, and breastfeeding initiation. These authors collected survey data from 624 women between 35th and 39th weeks of gestation about their childbirth fear, anxiety, attendance at childbirth education classes, choice of health-care provider, and expectations for interventions; the authors then linked women's responses to their intrapartum records. Findings suggest that older, more educated, and nulliparous women were more likely to attend childbirth education classes than younger, less educated, and multiparous women. Attending prenatal education classes was associated with higher rates of vaginal births among women in this study sample. Rates of labor induction and augmentation and use of epidural anesthesia were not significantly associated with attendance at childbirth education classes.

In a study designed to investigate the implementation of an evidence-based, streamlined education process that included a comprehensive education booklet, individualized education plan, and integration of education into the clinical pathway, along with nurse education to improve the quality and efficiency of postpartum education during hospitalization, authors Barbara Buchko, Connie Gutshall, and Elizabeth Jordan describe changes in the quality of discharge teaching for new mothers and efficiency of the education process for registered nurses before and after implementation of an intervention. Results indicated that a comprehensive educational booklet and enhanced documentation can improve efficiency in the patient education process for nurses.

In this issue's "Tools for Teaching" column, associate editor and regular columnist Judith Lothian teams up with columnist Barbara Hotelling to provide their top 10 tips on teaching Lamaze classes. According to these authors, Lamaze classes should help women think differently about birth, dispel myths, and ultimately make informed decisions that are right for them. They eloquently discuss how, in the current maternity care environment, this is a monumental task. In their column, Lothian and Hotelling describe 10 creative teaching tips that serve as a guide for teaching childbirth classes and ultimately facilitate learning.

Even for infants born at what is currently considered full term, a little more time in the womb may make a difference. Babies born at 37 weeks may do worse in math and reading tests later in life than babies born at 41 weeks.

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